LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

February 25, 2014

P&P MEMBERS PRESENT	P&P MEMBERS PRESENT, CONT.	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Monique Tula	Miguel Fernandez	Jane Nachazel
Bradley Land, *Co-Chair*		Aaron Fox	Craig Vincent-Jones
Michelle Enfield		David Kelly	
Lynnea Garbutt	**P&P MEMBERS ABSENT**	Red Liso	
Michael Johnson, Esq./Kevin Donnelly	Sharon Holloway	Terry Smith	**DHSP STAFF**
Abad Lopez	Mario Pérez, MPH	Jason Wise	Michael Green
Marc McMillin			**Sophia Rumanes**
Juan Rivera			Juhua Wu
LaShonda Spencer, MD			Dave Young

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *2/25/2014*
2) **Summary**: Suggested Directives, *2/25/2014*
3) **Letter**: Integrated HIV Prevention and Care Planning Groups and Activities, *2014*
4) **PowerPoint**: Overview of HIV Prevention Services in Los Angeles County, *2/13/2014*
5) **Program Backgrounder**: CDC's New High-Impact Approach to HIV Prevention Funding for Health Departments, *June 2011*
6) **Table**: County of Los Angeles, Department of Public Health, Division of HIV and STD Programs, Centers for Disease Control and Prevention (CDC) HIV Cooperative Agreement (PS12-1201) Due Dates
7) **Table**: HPG Membership and Stakeholder Profile, January 1, 2013 – December 31, 2013
8) **Graphic**: CDC Due Dates
9) **Guidance**: HIV Planning Guidance, *July 2012*
10) **Table**: Priorities and Planning (P and P) Committee FY 2010 Work Plan
11) **Spreadsheet**: Calculating the Values of the Percentages Used in the Priority- and Allocation-Setting Process, *2/25/2014*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:45 pm.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order with Items 8 and 9 reversed **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented **(*Postponed*)**.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

5. **COMMITTEE COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
   - Mr. Rivera said many California Department of the Treasury payments for consumer plans with Covered California Anthem Blue Cross and Blue Shield are being held rather than processed. State records show the payments have arrived.

- Some consumers, fearing loss of coverage, have submitted payments themselves. Those payments are processed, but that creates another problem because a processed payment "verifies" that insurance is active. Consumers are faced with scrambling to find funds for the next payment while waiting for State payments to be processed.
- He has called the call center, but was told the center was not in the United States and had no answers. A Blue Shield representative said the Los Angeles County plan was not Blue Shield, but through a subcontractor. He was able to obtain the number for a Blue Shield executive who promised to look into the matter.
- Mr. Rivera also talked to the OA-HIPP division supervisor. He said they were aware of the situation and had made calls, but received no answers from Blue Shield. Most new OA-HIPP applications, 90% or 200 consumers, are for Blue Shield PPO.
- Mr. Vincent-Jones suggested advising Ryan White providers continue covering patients until they are accessing services through their insurance. Mr. Rivera said providers might help with medical care, but ADAP will not cover medication costs unless it receives a termination letter from the insurance carrier saying that the person has been dropped. Mr. Vincent-Jones said the Office of AIDS could also provide verification that services are not being provided.
- Mr. Fox noted HRSA "strongly encourages" consumers to join marketplaces, but they may stay in Ryan White.
- On another matter, Mr. Fox reported that State ballot initiative AB 1266 did not receive sufficient signatures to go forward. It would have reversed recent legislation that allows transgender students to choose rest room facilities and sports teams.

➲ Mr. Rivera will forward the Blue Shield executive's phone number to Mr. Vincent-Jones.
➲ Mr. Land invited Mr. Rivera to join the stakeholders' phone call with the State.
➲ Mr. Fox suggested contacting the Department of Managed Health Plans and Mr. Vincent-Jones suggested contacting the Insurance Commissioner.
➲ Refer delayed health plan processing of Department of Treasury premium payments to Public Policy Committee.

6. CO-CHAIRS' REPORT:

- Mr. Land reported the Executive Committee asked all committees to utilize Item 10, Next Steps, on their agendas. The Commission is now larger and has expanded responsibilities with a small staff. PP&A responds to set timelines so may not be able to substantially reduce its agenda, but it is important to prioritize work to pace it reasonably.
- The Executive Committee also addressed mentorship. The Commission is addressing a great deal of information and there may be insufficient time during meetings to explore every question fully. The co-chairs stand ready to help directly or to identify someone a commissioner might be more comfortable with to review material. Mr. Johnson added it is normal to feel overwhelmed at the six-month mark. He encouraged people to stay engaged and continue asking questions.

A. PP&A Regular Meeting Schedule:

- Mr. Land said currently four committees meet in the fourth week of the month. Staff has suggested moving PP&A to the third week. Mr. Vincent-Jones added it is difficult for staff to complete work from each of the committees for the Commission meeting. Distributing meetings better will allow time to prepare work for Commission presentation.
- Mr. Fox asked about the PP&A motion at the February Commission meeting. Mr. Vincent-Jones replied some decisions were made at the 1/28/2014 PP&A meeting, but some FY 2013 dollar amounts were inaccurate. PP&A will review current data today and may choose to make adjustments. Any adjustments will be presented at the Commission.
- Mr. Kelly appreciated the need to space out work, but he noted PP&A has had extra meetings at times and there are also work groups. It is important to take all the work into account.
- Several members have obligations in the afternoon and preferred moving the meeting up one half-hour.

MOTION #3: Retain the regular meeting time of the Planning, Priorities and Allocations (PP&A) Committee, but advance the regular meeting day from the fourth Tuesday of the month to the third Tuesday of the month **(*Passed by Consensus*)**.
MOTION #3A: ***(Land/Ballesteros):*** Change the regular meeting time of the Planning, Priorities and Allocations (PP&A) Committee from 1:30 pm to 4:30 pm to 1:00 pm to 4:00 pm **(*Passed by Consensus*)**.
MOTION #3B: ***(Land/Ballesteros):*** Schedule special meeting to complete P-and-A on 3/4/2014, 1:00 pm to 4:00 pm **(*Passed by Consensus*)**.

B. PP&A Committee Scope of Responsibilities: This item was postponed.

7. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT:

A. Prevention Planning Rules and Requirements:

- Ms. Rumanes, Chief, HIV and STD Prevention Services, called attention to the letter from HRSA to Ryan White HIV/AIDS Program and CDC HIV Prevention colleagues that supports integrated planning, reports and activities. The letter

confirms that the Ryan White Parts A and B Comprehensive Plans and the CDC Jurisdictional HIV Prevention Plan will be due in September 2016. Los Angeles County is ahead of the curve in integrating its planning.

- She briefly reviewed the evolution of CDC and local HIV prevention thinking from 2010 to 2013: CDC Program Collaboration/Service Integration (PCSI) White Paper, June 2010; multiple test and treat efforts including showing how treatment is seen as prevention, 2009 and 2010; and release of the National HIVAIDS Strategy (NHAS), July 2010.
- In September 2010, the County was awarded a grant for CDC Enhanced Comprehensive HIV Prevention Planning (ECHPP) which allowed DHSP to work on aligning prevention and care efforts and NHAS. The CDC Funding Opportunity Announcement (FOA) was released in June 2011 with a new formula and High Impact Prevention (HIP) approach.
- Internally, the integration of DHSP was announced in February 2011. DHSP launched its new HIV testing model, New Directions, in July/August 2011. Concurrently, it was implementing Medical Care Coordination (MCC) and participating in the formation of the newly integrated planning body.
- The CDC FOA totals $15,623,277 with: Category A, HIP, $11.7 million; Category B, Expanded HIV testing for disproportionately affected populations, $2.3 million; Category C, Demonstration projects,$1.5 million.
- DHSP Category A programs include: targeted HIV and STD testing, Prevention For Positives, Linkage To Care (LTC), condom distribution, policy initiatives and some social marketing. The CDC considers these core prevention activities.
- The CDC calls Category B expanded testing, but is implemented as integrating routine testing in clinical settings.
- The County won competitive funding for its Category C demonstration projects. These are Project Engage, Navigation Program and activities around planning the use of HIV surveillance for public health purposes, e.g., syndemic planning.
- The full prevention portfolio includes non-CDC funded services, e.g., medical care/treatment, partner services and PrEP. Prevention and care lines become more blurred since infection rates decline drastically as people are diagnosed and moved into care/treatment. Consequently, getting and keeping people in care is a key public health measure.
- Total prevention funding is approximately $20 million. Most other funding is Net County Cost (NCC). There are some other grants through the California Health Research Program, some substance abuse prevention funding and a $3 million CDC grant for STD prevention and control. There is no longer any State prevention funding.
- Mr. McMillin asked if any prevention approach changes were anticipated due to the CDC's recent revision of its terminology from "unsafe sex" to "condomless sex." He supported the change since traditionally people who do not use condoms have been grouped indiscriminately as "high risk" which is not necessarily true.
- Ms. Rumanes was unaware of the terminology change, but noted geography may also be used as a proxy for "high risk," e.g., if an area has a high HIV prevalence then any individual encounter carries a higher risk.
- The CDC has moved in the last few years to cost effective, scalable activities such as testing, treatment and prevention for positives. It has moved away from programs for smaller group sessions and individual interventions. Individual jurisdictions may support those, but the CDC has become more prescriptive with an emphasis on scalable efforts.
- Mr. Fox asked if the finalized Cooperative Agreement categories were new or pre-existing. Ms. Rumanes replied some were pre-existing but, for example, testing was revised to meet NHAS targeted testing goals, Prevention for Positives was increased, some aspects of LTC are new and some new policy initiatives respond to legislation. Social marketing is new, e.g., planning began with ECHPP for a newly launched condom demonstration project.
- The Cooperative Agreement plan reflects which activities will be scaled up or down. The CDC Program Backgrounder identifies core prevention programs which must constitute a minimum of 75% of Category A funding: testing, prevention for positives which includes LTC, condom distribution and policy initiatives.
- An example of an initiative is developing HIV surveillance and testing protocols to improve LTC programming. Pilots can then be launched to test HIPPA, IRB and other protocols while funding staff. DHSP has learned that many testers already know they were HIV+. That lowers the testing program's positivity rate and raises the question of why people retest, e.g., they may be seeking incentives. It does offer the opportunity to re-engage people in care however.
- Up to 25% of Category A funds can be used for other proven HIV activities: Evidence-Based Interventions (EBI) for high-risk populations; social marketing, media and mobilization; PrEP and PEP; jurisdictional HIV prevention planning; capacity building and technical assistance; program planning, monitoring and evaluation, and quality assurance.
- Up to 5% can also be used for STD activities such as screening.
- DHSP supports EBI and some of the social marketing and media also supported through NCC funds. It is not currently supporting PEP or PrEP because CDC guidance prohibits funding medications which are a major part of the expense. It had funded PEP and PrEP under ECHPP. Mr. Smith suggested advocating for medication coverage. Ms. Rumanes said DHSP had raised the issue and was told that CDC is not a HRSA fund.

- Ms. Rumanes noted Category B was previously a separate grant which was rolled into the Cooperative Agreement. The only requirement is that a minimum of 70% must be used for opt out HIV screening. The remaining 30% is for targeted testing. DHSP supports routine HIV screening programs in jails and clinics.
- The County was lucky to receive the Category C funding for its HIV surveillance demonstration project Engage, which incentivizes people to bring others they know into care, and Navigation, which brings people into care through a Medi-Cal clinic. Programs are being evaluated and best practices reviewed for a possible internal DHSP LTC program.
- Mr. Lopez asked about the graphic showing 37% of PLWH in the United States live in 10 cities. Ms. Rumanes replied the graphic reflects the impetus for the CDC's new HIP funding approach which aligns resources with prevalence.
- Mr. Fox noted there was a common belief that Ryan White funding would decline over time in lieu of the Affordable Care Act (ACA) and asked if that applied to CDC funding. Ms. Rumanes said the main focus of CDC comments is to use funding effectively. The CDC also repeatedly asks how jurisdictions plan to maximize third party payers for testing, but has offered no guidance. There have been no funding decreases to date apart from sequestration.
- The current HIP 5-Year Cooperative Agreement term is 1/1/2012 to 12/31/2016. The Comprehensive HIV Plan (CHP) is for 2013 to 2017 so there is a slight discrepancy, but DHSP submitted a revision to correspond to the CHP.
- The Annual Report for the previous January through December is due March 31st each year. The report includes a narrative on successes, challenges and substantial changes as well as data charts. It also includes the HIV Planning Group (HPG) Membership and Stakeholder Profile. The CDC requires meaningful engagement with the community and the HPG. It specifically asks for changes to the HPG or its guidance, its engagement process, successes and challenges.
- The Interim Progress Report is due each September with a report on the first six months of the year. It can also serve as an application for the next year's jurisdictional HIV plan, in this case the CHP. It includes a narrative, data charts and an HPG (Commission) Letter of Concurrence. The Commission historically committed to revise its plan annually while the Prevention Planning Committee (PPC) generally restricted itself to updates based on input from various task forces.
- The HIV Planning Guidance details HPG body, member and co-chair responsibilities. Ms. Rumanes noted the CDC was previously prescriptive in asking the HPG to provide specific intervention funding recommendations, e.g., in the past the PPC recommended 50% of funding for Health Education/Risk Reduction, 20% to testing and so on. Now the HPG is to inform development or update the plan so recommendations can be to scale activities up/down or add activities such as PEP or PrEP. She recommended beginning the discussion on what the Commission wants now.
- Mr. Land asked about some of the previous successes. Ms. Rumanes replied the PPC was very interested in crystal meth use among MSM. The PPC formed a time-limited task force of community experts to review literature and develop recommendations for additional assessment and programs. That resulted in an RFP that doubled funding.
- Another example was an emphasis on changing testing and partner services modalities to reduce infections. DHSP has consequently increased testing and the number of people diagnosed.
- Mr. Smith added the PPC was effective in engaging people not normally involved to receive input, e.g., via the African-American MSM Task Force and the Transgender Task Force. Colloquia also provided input from researchers.
- Mr. Ballesteros asked how DHSP responded to PPC recommendations. Ms. Rumanes said DHSP used them as the basis for RFPs. Mr. Smith noted the PPC did not address allocations, but focused on developing and fine-tuning priorities throughout the year, e.g., through identifying and hearing from pertinent researchers.
- Ms. Rumanes added PPC meeting agendas were often built around a specific subject such as biomedical interventions with reports from researchers followed by discussion. It also worked to develop recommendations for populations with small absolute numbers of PLWH, but high infection rates.
- Ms. Tula noted the last FOA was prescriptive and asked if there would be more flexibility. Ms. Rumanes said she probably would not use "flexibility," but the Guidance provides the opportunity to inform and make recommendations.
- Mr. Kelly felt the question is one of process in addressing these grants. The Community Engagement Task Force is discussing colloquia going forward, but they may have a different purpose than in the past. He asked about DHSP expectations for the planning body to effectively engage the community and provide policy guidance.
- Ms. Rumanes said DHSP would like is a very strong planning body to help inform decisions. DHSP is very supportive of community planning. The fact that there is now one body can facilitate looking at prevention as part of the continuum especially regarding policy integrating prevention, treatment and care. The Commission itself should determine what policies it wants to address and what it wants to see from DHSP. From the prevention perspective, for example, she would like the Commission's perspective on PEP and PrEP, LTC and how MCC is working for the County.
- Mr. Fernandez asked about efforts to require routine HIV testing. Mr. Vincent-Jones said the Commission is on record as supporting routine testing and the Public Policy Committee has prioritized it. Medicaid does cover it, but there are

questions about coverage by various Covered California plans which are being explored. Public Policy had been working closely with the 2nd District, but interest faded when Medicaid included it.

- Mr. Fernandez said routine testing reduces stigma by making it a standards procedure. Mr. Fox said Public Policy has sought mandatory opt out legislation, but has been unable to move it far. There is still a problem with primary care providers who are often uncomfortable, lack LGBT culturally competency and do not know how to talk about testing.
- Mr. Kelly urged DHSP to review effectiveness in addition to scalability for an activity, e.g., a UCLA presentation described various activities along with funds spent divided by people benefited to evaluate effectiveness. He added Commission input will be most effective if DHSP provides as much information as possible about a proposed activity.
- Mr. Land asked if DHSP had recommendations for the Commission to consider especially for the September Cooperative Agreement Interim Progress Report. Ms. Rumanes felt the Commission was already engaged in effective discussions. She thought it important to highlight disproportionately affected populations. DHSP is very interested in young, African-American men, especially MSM, who have a very high incidence. A different approach is needed. Many identify as being "youth" first rather than African-American or Latino so DHSP is looking at youth services.
- Mr. Land asked about youth focus groups. Ms. Rumanes said DHSP had done some, but more input was needed.

B. FY 2015 Priority- and Allocation-Setting (P-and-A): This item was postponed.

8. EXECUTIVE COMMITTEE 2014 WORK PLAN: This item was postponed.

9. FY 2013-2014 PRIORITY- AND ALLOCATION-SETTING (P-AND-A): Attendees stated their conflicts of interest.

A. FY 2013 Allocations and Expenditures:

- Mr. Vincent-Jones developed an initial model for FYs 2013 and 2014, but realized it could be reformulated so it could be used going forward simply by plugging in new numbers. This can also contribute to discussions on how to make financial reports more usable. He kept that input in mind in developing the model. Next year the model can be further expanded including accommodation of prevention and STDs.
- The model now includes Parts A, B and Minority AIDS Initiative (MAI). Administrative fees are deducted from each funding source as follows: Part A, 15%; Part B, 10%; and MAI, 10%. The model can also recalculate increases or decreases automatically, e.g., if funding were cut 7% then the model could recalculate data to reflect the 7% reduction.
- It became particularly clear this year with the variety of funding sources that it is necessary to discuss allocations in dollars. At the same time, percentages are preferable for actual allocations since funding never perfectly equals percentages. The model can convert dollars to percentages or percentages to dollars simplifying those discussions.
- Mr. Vincent-Jones and Mr. Young have reviewed the FY 2013 original allocations, modifications, dollar amounts for both, DHSP year-end projections and variances. It is still possible to modify those allocations.
- The allocation for Medical Outpatient/Specialty is approximately $3 million less than anticipated expenditures. DHSP has now incorporated Medication Assistance and Access into Medical Outpatient/Specialty reducing the variance to $1.5 million. NCC can compensate for the remaining variance, but PP&A can also use allocations to send a message. In this case, the Commission has emphasized Oral Health Care for the past five years yet is now under-allocating the category. On the other hand, if Oral Health Care is increased, funds would need to be cut elsewhere.
- Mr. Kelly felt this was an unanticipated worst case scenario since expenditures exceed funds. Mr. Vincent-Jones replied contingencies actually anticipated a worst case scenario shortfall of up to $10 million so he felt this was fairly good.
- Estimates were that migration to ACA would save significant funds. Data regarding FFS was unavailable. In retrospect, migration did not save as much as estimated and FFS may have increased expenditures. The two major contingency scenario drivers were the number of those migrating and the amount of the award.
- Mr. Vincent-Jones reviewed estimated allocation/expenditure variances: MCC, $341,217 over-allocation; Mental Health Services, $265,063 over-allocation; Benefits Support, $197,739 over-allocation; LTC, services identified are part of MCC in FY 2013 and transfer to LTC in FY 2014; Transitional Case Management, $100,595 significant over-allocation in Part A as well as in MAI; Retention In Care Services, $211,093, under-allocation primarily due to Nutrition Support augmentation; Substance Abuse Services and Home-Based Care variances are minimal.
- He noted co-chairs had requested his recommendations which he usually does not offer. He did recommend reviewing areas inconsistent with overall management. The most notable of these is Oral Health Care, $811,488 under-allocation.
- Mr. Land noted DHSP contracted more than allocated in some cases, but Mr. Vincent-Jones said they could do so. PP&A based its recommendations on the best estimates available in a quickly changing landscape.
- Mr. Land wanted to devote sufficient time to addressing questions especially regarding FFS rates.

MOTION #4: Adjust FY 2013 end-of-the-year modifications to allocations, as necessary **(*Postponed*)**.

B. FY 2014 Allocations:

- Mr. Vincent-Jones noted the second section of the model addresses FY 2014 allocations, modifications and variances.
- The third section provides the formula used to confirm 1/28/2014 meeting decisions decreasing the six highest cost categories by 10%. Mr. Vincent-Jones noted a small amount of the total 10% goal remained after those reductions.
- He asked confirmation of whether the remaining amount should be cut from all categories or the original six.
- ➲ Confirmed that the remainder of the 10% reduction to be taken from the original six categories.
- ➲ Mr. Vincent-Jones will email the FY 2013 and 2014 files and will separately email the file with the finalized formulas in two or three days.

MOTION #5: Modify FY 2014 allocations, as appropriate **(*Postponed*)**.

C. FY 2014 Directives:

1. *Pol./Proc.: #09.5205: Commission Directives to Administrative Partners:*

- Mr. Land noted the list of suggested directives from the 1/21/2014 and 1/28/2014 meetings which include, e.g., improving the speed of provider invoicing and a food referral list in a format accessible for the community.
- Mr. Rivera said in his prior experience providers received a list of resources from DHSP. They reviewed the list with new clients and offered to assist in applying for pertinent resources. Mr. Land noted there had been a presentation on food resources. It identified several hundred, but not all offered services helpful for PLWH. There are still the AIDS Project Los Angeles Necessities of Life Program, Project Angel Food, Project Chicken Soup and Aid for AIDS.
- Another highlighted area was the need to advocate for transportation services, e.g., participation in Section 8 hearings with the Metropolitan Transportation Authority and Federal government. Services such as Access are addressed. People with disabilities participate, but PLWH generally do not. He participated in the past. Hearings are local and can change bus routes, e.g., his district was successful in changing Antelope Valley bus routes.
- Directives are not solely for DHSP as the administrative agency, but to any partner including the Department of Public Health and the Commission itself. Directives to DHSP should be prioritized since it is also short-staffed.
- Mr. Vincent-Jones said the directive procedure is part of the Ryan White process as noted in the attached HRSA materials. Directives provide instructions in implementing priorities-and-allocations to ensure they best meet the need. The CDC lacks a similar process, but supports the HPG's direction in implementing recommendations.
- Also attached to the directives is a communication form that has been used by the Commission in the past. It still meets current policy and can be used until the Commission determines another format.
- The Commission usually generates three or four major directives a year. There are three formal levels: expectations which the Commission wants done, recommendations which the Commission would like done and guidance which would be desirable. Directives are formal communications, but most interactions are informal.
- Mr. Vincent-Jones noted several items listed do not need to be directives because they are routine work of the various bodies, e.g., the Public Policy Committee is charged with advocacy and Operations with seeking other funding sources. DHSP routinely backfills cuts with NCC funds to the extent it is able to do so and also provides presentations as requested such as on Substance Abuse and Home-Based Care service categories.
- Mr. McMillan said the request for a report on Home-Based Care was based on ongoing audits and the possibility of some change in funding utilization due to the category's opportunities for abuse. Ms. Nachazel noted Mr. Pérez had distinguished between what may be a Medi-Cal audit and routine annual DHSP audits of all programs. Mr. Vincent-Jones said the Commission can request a complete presentation including audit information from DHSP.
- Mr. Johnson was concerned with the lag time in submission of provider invoices previously reported by Mr. Young. He urged a robust discussion with DHSP on whether it may be appropriate for a directive to require timely invoicing from community partners to aid DHSP in receiving timely information and improve planning data. That would require programmatic changes which would need to be explained, e.g., a program information notice or change in contracting policy. Mr. Vincent-Jones noted the Commission cannot engage in procurement activities.

2. Status of Prior Year's Directives: This item was postponed.

1. *FY 2014 P-and-A Directives:*

- Mr. Vincent-Jones noted the meetings on both 1/21/2014 and 1/28/2014 requested a full explanation from DHSP of the financial impact of Fee-For-Service (FFS) on aggregate funding for care and prevention. Data will likely not be available for six months, but both meetings raising the issue indicates it should be prioritized as an expectation.
- ➲ The Commission has been discussing more active participation with DHSP in information referral, including food services, for the past 18 months. Staff will also re-present the prior report which did not reflect service duplication.

- Refer advocacy for transportation services to the Public Policy Committee as a priority concern.
- Request presentations by DHSP on Substance Abuse and Home-Based Care at their earliest possible convenience.
- Directive/Expectation: DHSP: Bring options to address overdue invoices back to PP&A for input. The Commission cannot engage in the mechanics of financing or monitoring services, but can offer input to DHSP for it to use in improving a system that significantly impacts planning.
- Directive/Expectation: DHSP: Work with DHSP to improve understanding of the Ambulatory Outpatient Medical FFS rate with a report for presentation within six months.
- Directive/Expectation: Commission: Address in collaboration with DHSP why the Department of Mental Health (DMH) has not fulfilled its statutory obligation to provide services possibly via a letter to the Board. Mr. Vincent-Jones will identify whether DMH has a commission and, if so, how to contact it.
- Delete bullets 4, DHSP backfilling of cuts; and 7, Public Policy seeking out/advocating for funds, as redundant.
- Mr. Vincent-Jones will update the FY 2014 P-and-A memorandum with the directives for presentation at the next Commission meeting.

MOTION #6: Revise and approve the FY 2014 Priority- and Allocation-Setting directives, as presented **(*Passed by Consensus*)**.

10. **NEXT STEPS**: Mr. Land summarized that staff will schedule presentations discussed and Mr. Vincent-Jones will update the FY the FY 2014 P-and-A memorandum with the directives.

11. **ANNOUNCEMENTS**: There were no announcements.

12. **ADJOURNMENT**: The meeting adjourned at 4:30 pm.